

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address:	MFDR Tracking #:	M4-10-3346-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: STANDARD FIRE INSURANCE CO Box #: 05	Date of Injury:	
	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "I am sending this letter to see if you can help me with my medical fee reimbursment [sic] dispute. I send a letter recently to this person (William Weldon) which I thought he was a case worker for the travelers ins. and he was not, I received a call from the case worker for this ins. telling me that why did I call & faxed [sic] a letter to him explaining the false information stated on the letter I received before, since he is the lawyer for the insurance not a worker. The reason I did this was because the addresses on the letter they send [sic] me are wrong it states to contact him if I have any questions. I'm sending copies of what I send [sic] and what they send me. I would really appreciated [sic] if we could go over my medical reviews since all the information they have is not true."

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Total Amount Sought \$3,477.14

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The Claimant's Request for Medical Fee Dispute Resolution involves reimbursement for prescriptions paid for out of pocket by the Claimant. The Claimant's treating doctor prescribed and the Claimant filled multiple prescriptions for Viagra over the course of four years. During the time period the Claimant was receiving Viagra, the Carrier had two Required Medical Examinations with Dr. Obermiller to address the medical necessity of the prescription for Viagra. In both RME reports, Dr. Obermiller opines, based on the diagnostic studies completed by the Claimant's referral doctor, that the Viagra prescription was not reasonable and necessary to treat the effects of the Claimant's compensable injury. The Carrier informed the Claimant of the results of the RME report, and denied reimbursement for the Viagra prescription on the basis it was not reasonable and necessary. Eventually, in later December of 2009, the Carrier evaluated diagnostic evidence from a Rigiscan, previously evaluated by Dr. Obermiller, submitted by the Claimant's referral doctor, Dr. Stephenson. Dr. Stephenson and Dr. Obermiller disagreed as to the findings of the Rigiscan diagnostic. Based on that re-evaluation, the Carrier agreed to pay for trial medication going forward to attempt to address the Claimant's alleged erectile dysfunction. Once the Carrier agreed to pay for the Viagra and after filling four years of prescriptions, the Claimant immediately told his doctor the Viagra did not work, requested a change to a different medication, and has filled no more prescriptions for Viagra. Consequently, the Carrier maintains the position that the Viagra is not reasonable and necessary medical treatment for the Claimant's compensable injured based on the opinion of Dr. Obermiller and the Claimant's statements. As the Carrier's denial of reimbursement is based on medical necessity, this Request for Medical Dispute Resolution is improper under Rule 133.307(e)(3)(G), and should be dismissed."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS				
Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11/07/05 – 01/09/09	No EOBs submitted	Out-of-Pocket expenses – Prescription Medication	\$3,477.14	\$0.00
Total Due:				\$0.00
PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION				
<p>1. Medical Fee Dispute Resolution received the request for medical dispute resolution on March 17, 2010. Dates of service 11/07/2005 through 01/09/2009 were not filed within the one-year filing time as required by 28 Texas Admin Code Section §133.307(c)(1); therefore, these dates of service are not eligible for review.</p> <p>2. Pursuant the 28 Texas Admin Code Section §133.307(e)(3)(E) the request for medical fee dispute resolution is untimely. As a result, the amount ordered is \$0.00.</p>				
PART VI: GENERAL PAYMENT POLICIES/REFERENCES				
<p>Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311 Texas Administrative Code Sec. §133.270, §133.305, §133.307, and §134.504</p>				
PART VII: DIVISION DECISION				
<p>Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to \$0.00 reimbursement.</p>				
<p>_____ Authorized Signature</p>		<p>_____ Auditor III Medical Fee Dispute Resolution</p>		<p>July 6, 2010 _____ Date</p>
PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL				
<p>Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. Please include a copy of the Medical Fee Dispute Resolution Findings and Decision together with other required information specified in Division Rule 148.3(c).</p> <p>Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.</p> <p>Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.</p>				